Supreme Court, U.S.
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No. 991833

IN THE
SUPREME COURT OF THE UNITED STATES

BAPTIST MEMORIAL HOSPITAL,
Petitioner,

v.

BAKERY & CONFECTIONERY UNION
& INDUSTRY INTERNATIONAL
HEALTH BENEFITS FUND,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

1. Whether the time limit for submitting claims to an ERISA-regulated employee health benefit plan should be tolled as a matter of federal common law when the plan beneficiary is incapable of providing information to the health care provider regarding coverage under the plan and the provider is unaware of the existence of coverage.

PARTIES TO THE PROCEEDING

The parties to this proceeding are set forth entirely in the caption of the case, and none of the parties are wholly owned subsidiaries or affiliates of publicly owned corporations.

PETITIONER

Baptist Memorial Hospital, a not-for-profit Tennessee corporation.

RESPONDENT

The Bakery and Confectionery Union and Industry International Health Benefits Fund, a self-insured multi-employer benefits plan that provides medical benefits to union-represented employees of participating employers and their dependents.

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PETITION FOR A WRIT OF CERTIORARI

The Petitioner Baptist Memorial Hospital respectfully prays that a writ of certiorari issue to review the opinion of the Court of Appeals for the Sixth Circuit entered on February 16, 2000.

OPINIONS BELOW

The opinion of the Court of Appeals appears in Appendix A at 1a.

The opinion of the District Court judge, dated July 9, 1998, is included in Appendix B at 6a. The opinion of the District Court has been published at 13 F.Supp.2d 696 (W.D. Tenn. 1998).

JURISDICTION

The opinion of the Sixth Circuit was entered on February 16, 2000. This Petition for Writ of Certiorari is filed within ninety days of the Order affirming the opinion of the District Court. The Court's jurisdiction is invoked pursuant to 28 U.S.C. §1254(1).

Appellate jurisdiction in the Court of Appeals was invoked pursuant to 28 U.S.C. §1291, and jurisdiction in the District Court was based upon federal question under 28 U.S.C. §1331 and the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1132.

STATUTORY PROVISIONS INVOLVED

This appeal implicates three specific statutes which are part of ERISA, 29 U.S.C. §§1132(a), 1133 and 1144, and the pertinent portions of these statutes are set forth in Appendix C at 25a.

STATEMENT OF THE CASE

A. Introduction

This case arises from the denial of a claim for medical benefits under an ERISA-regulated employee health benefit plan for hospital services provided to David Marsaw by Baptist Memorial Hospital. Mr. Marsaw was covered under the Medicare Program and two employee health benefit plans: (1) as a retiree-participant in his former employer's health benefit plan, the Ford UAW Retiree Program (the "Ford Program"), and (2) as the dependent spouse of an actively working participant in the Bakery and Confectionery Union and Industry International Health Benefits Fund ("the Fund").

B. Facts

The facts of this case are undisputed. While visiting his sister in Memphis, Tennessee, David Marsaw, a resident of Chicago, Illinois, began experiencing several physical problems which caused him to go to Dr. Thomas West, a physician in the private practice of medicine. Dr. West saw Mr. Marsaw on September 12, 1991, and immediately admitted him to Baptist Memorial Hospital ("BMH") through the emergency department with the principle diagnoses of (1) Parkinson's disease and (2) urinary bladder neck contracture with bladder outlet obstruction, and secondary diagnoses of

(1) Parkinson's dementia complex; (2) heart disease in the right ventricle and hypertrophy; (3) subendocardial myocardial injury; (4) respiratory failure; and (5) hyporegenerative anemia.

During Mr. Marsaw's inpatient hospital stay from September 12, 1991 through March 4, 1992, three operations were performed, and he experienced several complications including multiple episodes of respiratory failure that required him to spend much of his hospitalization on a respirator in the intensive care unit.

At the time of his admission, Mr. Marsaw was mildly confused, and his confusion worsened to the point that at the time of his discharge he was "frankly demented" according to his treating physician.

At the time of his emergency admission to BMH, Mr. Marsaw's wife was at home in Chicago, and he was taken to the hospital by his sister only. The hospital was furnished medical cards that showed Mr. Marsaw had coverage under Medicare and the Ford Program, but there was no reference to his wife or the possibility of coverage under the Fund.

BMH personnel verified Mr. Marsaw's coverage under the Ford Program, but this coverage was only for dental and vision expenses; the Ford Program also included a Humana HMO, but BMH was not a participating provider. Mr. Marsaw was therefore listed as a Medicare (primary) patient.

The Medicare intermediary paid BMH's claims for primary benefits. In processing BMH's claims, the Medicare intermediary discovered that another payer had paid primary health benefits on behalf of Mr. Marsaw to other health care

providers. On July 26, 1993, the intermediary took back the Medicare payments that had been made to BMH in March 1992.

The Medicare intermediary did not formally deny BMH's claim for primary benefits until November 18, 1993, and, even then, it did not advise BMH of the identity of the primary payer.

On February 21, 1994 -- almost two years after the date of Mr. Marsaw's discharge -- the Medicare intermediary finally advised BMH that the Fund was the entity that had paid primary benefits on behalf of Mr. Marsaw to other health care providers. BMH immediately contacted the Fund and submitted a claim to it.

The Fund denied BMH's claim on the grounds that it was made beyond the plan's limitations period and because the admission was not pre-approved.[1] BMH appealed the denial to the Fund's Appeals Committee, and, in support of its appeal, BMH submitted affidavits which showed that the hospital was furnished with only limited information concerning Mr. Marsaw's coverage for medical benefits and that he became incompetent during his hospitalization, the combination of which prevented BMH from discovering the possibility of coverage under the Fund.

The Fund presented no contradictory evidence, but the Appeals Committee affirmed the denial of the claim for the

---

[1] Although the Fund denied BMH's claim on the additional ground that Mr. Marsaw's admission was not precertified, there is no dispute that his admission was an emergency. Neither the District Court nor the Court of Appeals addressed the Fund's denial on this basis.

same reasons, *i.e.*, because the claim was untimely and because the emergency admission had not been pre-approved.

The Fund admits that it would be obligated to pay primary benefits for Mr. Marsaw's hospitalization if the claim for BMH's expenses had been timely made.

C. Summary of Course of Proceedings

BMH sued other parties in this declaratory judgment action. However, since the Fund admitted that its coverage was primary, the determinative issue was whether the Fund should have paid the claim for the hospital services provided to an admittedly covered participant in the Fund's plan. This issue was submitted to the District Court on cross-motions for summary judgment.

The District Court upheld the Fund's denial because the claim was not submitted within the Fund's time limit. Although the District Court acknowledged that the result was harsh, it declined to find that, as a matter of federal common law under ERISA, the Fund's time limit was tolled because of the dependent's incompetence, the hospital's ignorance of the existence of the dependent's coverage under the Fund and the Medicare intermediary's reversal of its original payment of primary benefits.

The Court of Appeals for the Sixth Circuit affirmed the ruling of the District Court in a *per curiam* opinion which similarly declined to provide equitable relief and create a remedy as a matter of federal common law.

D. Findings of the District Court

The District Court characterized the determinative issue and its holding in this case as follows:

> . . . Thus, the court reaches the controlling issue in this case: When applying the arbitrary and capricious standard of review, may the Court supplant an ERISA plan administrator's rational interpretation of an ERISA plan term through the creation and implementation of an equitable remedy under the auspices of federal common law?
>
> Considering the deference owed to the trustees' decision and the general rule that a federal court may not alter the substantive terms of an ERISA benefits plan unless the challenged term contravenes an ERISA policy, the Court must answer this question in the negative.

Order on Cross-Motions for Summary Judgment pps. 15-16 [Appendix at 21a].

The District Court acknowledged that "rigid application of the Fund's limitation period may produce a harsh result," but stated that it could not grant BMH's request for an equitable remedy because the Plan's time limitation for filing claims did not violate any fundamental ERISA policy. *Id.*, at 16 [Appendix at 22a].

E. The Sixth Circuit's Opinion

The Court of Appeals affirmed the judgment of the District Court based upon the same reasoning. The Sixth Circuit also distinguished the Eleventh Circuit's opinion in *Branch v. G. Bernd Co.*, 955 F.2d 1574 (11th Cir. 1992), on the ground that *Branch* involved a Congressionally-mandated time period for electing to continue coverage under an employee benefit plan, stating that "federal courts may not apply common law theories to alter the express terms of written benefits plans." The Sixth Circuit did not identify any reason for its refusal to apply well established concepts of the common law, such as equitable tolling, to extend the time for the hospital to submit a claim for services provided to an admittedly covered plan participant who was incompetent and unable to assist the hospital in identifying the correct primary payer within the time limit for filing claims under the terms of the private plan.

REASONS FOR GRANTING THE WRIT

The District Court and the Court of Appeals held that equitable tolling principles could not apply to the Fund's time limit as a matter of federal common law ***unless*** the time limit was contrary to an ERISA policy. This is not the law. There is no requirement either in the statute or the caselaw interpreting ERISA that a plan provision must be contrary to ERISA before a court may apply federal common law under the Act. The District Court and Court of Appeals should have held that the Fund's one-year time limit for filing a claim must be tolled as a matter of federal common law because rigid application of the plan's time limit without considering the reasons for the untimeliness of the claim is contrary to ERISA policy.

The judgments of the lower courts are in conflict with several Supreme Court decisions which hold that courts have been directed by Congress to create federal common law to further ERISA's remedial purposes of protecting employees and their beneficiaries' rights to receive benefits under ERISA-regulated benefit plans. The instant case is, in fact, exactly the type of circumstance where Congress envisioned courts would apply long-recognized common law rules to fill in the gaps in ERISA's remedial scheme.

1. ERISA's legislative history shows that federal courts are required to establish federal common law consistent with the Act's remedial scheme and purposes.

ERISA's legislative history shows that Congress intended federal courts to develop federal common law and fashion equitable relief under appropriate circumstances. For example, Senator Javits, one of the two principle sponsors of the Act, stated in the Conference Report that "[i]t is also intended that a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." 120 Cong. Rec. 29942 (1974). Senator Williams, the Committee's Chair and the Act's other principle sponsor, similarly emphasized that suits involving beneficiaries' rights "will be regarded as arising under the laws of the United States, in similar fashion to those brought under Section 301 of the Labor Management Relations Act." *Id.*, at 29933. Section 301 of the Labor Management Relations Act ("LMRA"), 29 U.S.C. §185, "authorizes federal courts to fashion a body of federal law" to be derived by "looking at the policy of the legislation and fashioning a remedy that will effectuate that policy." *Textile Workers v. Lincoln Mills*, 353

U.S. 448, 451, 457, 77 S.Ct. 912, 915, 918, 1 L.Ed.2d 972 (1957).

Congress unquestionably intended for courts to refer to trust law principles in interpreting ERISA's enforcement scheme, and a fundamental concept of trust law is that courts "will give to the beneficiaries of a trust such remedies as are necessary for the protection of their interests." *Massachusetts Mutual Life Ins. Co.*, 473 U.S. 134, 157, 105 S.Ct. 3085, 3098, 87 L.Ed.2d 96 (1985).

Contrary to the conclusion of the lower courts in the present case, Congress did not intend for federal courts to be reluctant create new rights and remedies for beneficiaries of ERISA-regulated plans, when appropriate, as a matter of federal common law. In fact, far from discouraging the courts from fashioning such relief, they have a *responsibility* to create, as a matter of common law, remedies which advance and are consistent with ERISA's remedial scheme and purposes. *Massachusetts Mutual Life Ins. Co.*, 473 U.S. at 157, 105 S.Ct.at 3098.

2. The Supreme Court has acknowledged Congress's mandate to create federal common law under ERISA.

On several occasions, the Supreme Court has noted that Congress expected the courts to develop a federal common law of rights and obligations under ERISA-regulated plans. *See, Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-111, 109 S.Ct. 948, 954, 103 L.Ed.2d 80 (1989)("[W]e have held that courts are to develop 'a federal common law of rights and obligations under ERISA-regulated plans.'"); *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 56, 107 S.Ct. 1549, 1557-1558, 95 L.Ed.2d 39 (1987);

Franchise Tax Board v. Construction Laborers Vacation Trust, 463 U.S. 1, 24, n.26, 103 S.Ct. 2841, 2854, n.26, 77 L.Ed.2d 420 (1983)("In addition, ERISA's legislative history indicates that, in light of the act's virtually unique preemption provision, *see* §514, 29 U.S.C. §1144 'a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans'"); *Varity Corporation v. Howe*, 516 U.S. 489, 497, 116 S.Ct. 1065, 1070, 134 L.Ed.2d 130 (1996) (" . . . Congress 'expect[ed] that the courts will interpret this prudent man rule (and the other fiduciary standards) bearing in mind the special nature and purpose of employee benefit plans' . . . as they 'develop a federal common law of rights and obligations under ERISA-regulated plans.'"). This Court, however, has not actually set forth any guidance for courts to employ in formulating the body of federal common law applicable to ERISA-regulated plans. The present case presents such an opportunity.

The need for courts to develop common law stems from the inability of Congress to anticipate every possible contingency and the impracticality of judges returning all unanswered questions to the legislature. As Justice Jackson stated in the concurring opinion in *D'Oench, Duhme & Co., Inc. v. FDIC*, 315 U.S. 447, 62 S.Ct. 676, 86 L.Ed. 956 (1942):

> Were we bereft of the common law, our federal system would be impotent. This follows from the recognized futility of attempting all-complete statutory codes, and is apparent from the terms of the Constitution itself. . . Federal common law implements the federal Constitution and statutes, and is conditioned by them. Within these limits,

> federal courts are free to apply the traditional common-law technique of decision and to draw upon all the sources of the common law.

Id., 315 U.S. at 472, 62 S.Ct. at 686.

Section 502(a) of ERISA, 29 U.S.C. §1132(a), establishes certain measures for the participants and beneficiaries of employee benefit plans to enforce their rights under ERISA and under the terms of their plans. *Massachusetts Mutual Life Insurance Company v. Russell*, 473 U.S. at 148, 105 S.Ct. at 3093. For example, a participant or beneficiary may file a civil action to obtain equitable relief to enforce any of ERISA's provisions or the terms of a plan. 29 U.S.C. §1132(a)(3)(B)(ii). Pursuant to Section 544 of ERISA, 29 U.S.C. §1144, Congress unquestionably pre-empted state law with respect to the regulation of employee benefit plans. However, it is clear that ERISA was not intended to be an all-complete code with respect to claims for medical benefits, because Congress could not have believed that the rights and remedies set forth in Section 502(a) would completely supplant the entire body of law from all of the several states relating to these types of claims. Congress plainly could not have anticipated every possible contingency, such as the combination of a plan participant's incapacity with a lack of information as to the participant's coverage furnished to the provider of services and the demand for repayment of primary benefits by the original primary payer which are the circumstances of the present case.

If this Court is going to fulfill Congress's mandate to formulate a body of federal common law to deal with issues involving the rights and obligations of employee benefit plans, the instant case presents an appropriate circumstance for it to

do so. Among other things, the Court needs to provide the lower courts with some general guidance for addressing such issues. Moreover, the Court should establish particular rules for the peculiar, undisputed facts of the present case, because the facts of the present case are likely to be repeated in the context of other benefit plans.

3. The lower courts in the present case failed to fulfill their responsibility to create federal common law under ERISA.

To date, none of the three tribunals in which BMH has raised the issue -- the Fund's Appeals Committee, the District Court and the Sixth Circuit -- has directly confronted the actual issue in this case. There is no question that the hospital's claim was untimely under the terms of the Fund's plan, and the timeliness of the claim for the hospital's charges is simply not an issue.

The hospital first asked the Fund to waive the time limit or to take into account the unique circumstances of the several reasons for the delay in submitting the claim to the Fund. In particular, BMH asked the Fund to consider the delay by the Medicare intermediary in processing the hospital's timely claims for primary benefits and the unexpected action by the Medicare intermediary of taking back its payments more than two years after the patient's discharge. The Fund declined to consider the patient's undisputed incompetence and the lack of information furnished to the hospital to toll the time limit for filing a claim.

The District Court declined to equitably toll the Fund's time limit for filing claims during the period of time that the

plan participant was incapable of advising the hospital of his coverage with the Fund, holding that it could not create federal common law because to do so would somehow require the court to alter the Fund's time limit. The District Court acknowledged that this produced "an unfair result" but held that it could not "alter the substantive terms of the plan" unless the Fund's time limit contravened ERISA policy. [Appendix at 21a]. The District Court reached its conclusion, at least in part, because of its reliance on the deferential abuse-of-discretion standard of review as to the Fund's "interpretation" of the terms of the plan. The fallacy with the District Court's approach with respect to the question of the Fund's "interpretation" of its time limit is that there is actually no interpretation to be made; there is no question that the claim for the hospital's charges was made long after the Fund's time limit for submitting claims had expired.[2]

The Sixth Circuit affirmed the District Court's judgment, reaching the unremarkable conclusion that the hospital's claim was not timely under the terms of the plan. The appellate court failed, however, to address in depth any reason why it would not be appropriate under the undisputed facts of the present case to create, as a matter of federal common law consistent with Congress's directive, an equitable remedy to prevent the beneficiary (or his survivors) from being burdened with the staggering amount of the hospital's bill for this lengthy hospitalization or for the

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[2] BMH has consistently contended in this litigation that certain language in the Fund's plan is ambiguous, but for purposes of this discussion and the District Court's analysis, there is no dispute that the hospital's claim was untimely under the terms of the plan.

hospital to take a significant loss, through no fault of its own, in furnishing life-saving services to the Fund's beneficiary.[3]

The narrow vision of the lower courts' rulings in the present case is inconsistent with this Court's previous pronouncements and with Congress's unambiguous directive that federal courts shall create a body of federal common law in appropriate circumstances to further ERISA's remedial purposes. Indeed, the lack of imagination by the lower courts in the present case is inconsistent with the ERISA's remedial goals, and it frustrates Congress's stated policies and purposes.

Both the Fund and the lower courts have failed to address the central issue in this case. Instead, they have repeatedly stated that the claim was not filed within the Fund's time limit to reach the obvious conclusion that the Fund could deny the claim because it was untimely. This type of shallow analysis begs the question and wholly fails to confront the issue of whether the time limit should be tolled as a matter of federal common law. Although the District Court noted the harshness of the result and this Court has repeatedly stated that lower courts are commanded by Congress to create federal common law, it is apparent that the District Court was reluctant to do so because there is no precedent from this Court which sets forth any guidance or parameters for courts to follow in creating such extra-legislative rules, such as equitable tolling during a beneficiary's incompetency.

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[3] The hospital's total charges for Mr. Marsaw's seven-month admission were $355,216.13.

4. The rule should be, as a matter of federal common law, that the time limit for submitting claims to an ERISA-regulated employee benefit plan is tolled when the beneficiary is incompetent and unable to assist a health care provider in making a claim or in determining that there is coverage under the terms of the plan.

The well recognized common law rule of equitable tolling has been applied in some cases involving claims under ERISA plans. As Judge Sarokin of the District Court for the District of New Jersey stated in holding that equitable tolling should be applied as a matter of federal common law under ERISA in the context of an incompetent plan participant and the statutory time period for electing continuation of coverage:

> In light of ERISA's recognized remedial purpose, which this court must construe broadly, it is inconceivable to this court that a statutory scheme which is otherwise so generous and protective of employees enrolled in employment benefit plans would in this instance ignore both equity and reason by requiring employees suddenly incapacitated and physically unable to secure their benefits to forfeit so basic a need as health care coverage.

Sirkin v. Phillips Colleges, Inc., 779 F.Supp. 751, 756 (D.N.J. 1991).

At least two Circuit Courts of Appeals – the Seventh and Eleventh – have held that equitable tolling should be applied as a matter of federal common law in cases involving claims under employee benefit plans governed by ERISA. *See, Branch v. G. Bernd Company*, 955 F.2d 1574, 1580 (11th Cir. 1992); and *Doe v. Blue Cross and Blue Shield of Wisconsin*, 112 F.3d 869 (7th Cir. 1997).

In *Branch*, COBRA's sixty-day period for a participant to elect to continue coverage under an employee benefit plan was held to be tolled during the participant's incapacity. The Eleventh Circuit held that the participant's death during the sixty-day period prevented him from having a full sixty days within which to make his election, and, under these circumstances, the court held that it was proper for a hospital employee to be appointed to act as the deceased's representative for the sole purpose of "electing" to continue the deceased's coverage, a result that allowed the hospital's claim to be covered by an employee benefit plan. The Eleventh Circuit in *Branch* concluded that equitable tolling should, as a matter of federal common law, apply to claims for continuation coverage under ERISA/COBRA, because it would effectuate Congress's broad purpose of enacting COBRA to provide continued access to affordable private health insurance in accordance with the general remedial purposes of ERISA. The effect of the court's ruling in *Branch* was to allow a self-interested party (a creditor-hospital) to employ a legal fiction that a deceased former employee had, through the court-appointed representative, elected to extend his coverage under his former employer's plan so that his final hospital bill could be paid. While this obvious artifice achieved the salutary purpose of providing payment of an employee's medical expenses, it was obtained under circumstances that are far less compelling than the undisputed facts of the present case.

The Sixth Circuit chose to narrowly read the Eleventh Circuit's ruling in *Branch* as not having any application outside the context of the sixty-day election period under the COBRA statute. Since there was no issue of continuation coverage in the present case, the Sixth Circuit held that *Branch* had no direct bearing on the analysis of BMH's request that, as a matter of federal common law, the court recognize an equitable remedy under factually similar circumstances.

In *Doe v. Blue Cross and Blue Shield of Wisconsin*, the Seventh Circuit held that a benefit plan was estopped from relying on a claimant's untimely filing because the plan had written a letter to the claimant's attorney confirming an agreement to delay filing a lawsuit until further discussions could be held. In reaching its decision, the Court in *Doe* noted that the doctrine of equitable tolling was "presumptively applicable" in federal suits. 112 F.3d at 875. The Seventh Circuit also made the following observation concerning the distinction to be made between a contractual limitation and a statutory one:

> We point out, in further support of our conclusion that ***the doctrine of equitable estoppel should be applied more liberally to a contractual limitations period, as here, than to a statutory limitations period.***

Doe, 112 F.3d at 877 (emphasis added).

Although the precise ruling in *Doe* is not the issue in the present case, the general principle is still applicable: Equitable tolling should be utilized to toll limitation periods under appropriate circumstances, especially if the limitation

period is set forth in the plan itself as opposed to a federal or state statute.

The undisputed circumstances of this case and the remedial and equitable purposes of ERISA demand that the Court fashion a remedy for a health care provider which provided valuable and substantial services to the beneficiary of an employee health benefits plan which, through no fault of its own, could not have submitted a timely claim. If courts refuse to fashion equitable remedies under the circumstances of the instant case to prevent an admittedly harsh result, health care providers will be reluctant to furnish services to plan participants. The lower court's refusal to fashion an equitable remedy under the circumstances of the instant case clearly contravenes ERISA's remedial purpose of protecting employees' rights under welfare benefit plans.

ERISA's goals and purposes would not be advanced by allowing a primary payer to escape responsibility for a substantial hospital bill merely because the district court and appellate court mistakenly believed that they were prohibited from tolling the plan's time limit for filing claims unless the limit contravened a specific ERISA policy. BMH is not suggesting that the Court should rewrite the Fund's time limit for filing claims. BMH does believe, however, that strict application of a plan's time limit for filing claims in every case without regard to the reason that a particular claim was not timely filed is inconsistent with ERISA's over-all remedial policies. The *effect* of tolling a time limit will undoubtedly be to extend the time limit, but it will not change the plan provision; it will advance the remedial goal of the Act.

Congress recognized that it could not anticipate every contingency, and, although ERISA is quite detailed in the regulation of the accounting responsibilities of plan

fiduciaries, the Act is relatively sparse in its treatment of the payment of health benefits. *Compare*, 29 U.S.C. §§1132, 1133 and 1144, which are the entirety of ERISA's statutory framework for the regulation of claims for health benefits. Indeed, ERISA's broad, comprehensive preemption of state law claims makes it absolutely imperative that courts fill the void with a body of federal common law since, at least with respect to this aspect of the Act, Congress did not attempt to enact an all-complete statutory code. Equitable tolling principles should be applied to toll the time limit for filing claims under an employee benefit plan during the beneficiary's incompetence as a matter of federal common law in order to further the goals of ERISA. The creation of federal common law in this manner is exactly what Congress had in mind when it enacted ERISA.

Given ERISA's significant role in the administration of employee benefit plans, the need for guidance from this Court on this issue is crucial. Where a beneficiary is incompetent and the health care provider is unaware of the existence of coverage, justice demands that a court fashion an equitable remedy through creation of federal common law in order to toll the time limit for filing a claim so that the provider can be reimbursed for the services provided to the beneficiary.

CONCLUSION

The Court of Appeals' decision in this case is inconsistent with the opinions of this Court and the language and legislative history of ERISA. If any case warrants creation of federal common law as Congress directed, this case is it. The Supreme Court has stated on several occasions that Congress has directed courts to develop a federal

common law to deal with issues involving the rights and obligations under ERISA-regulated welfare benefit plans; however, this Court has not actually set forth any guidance for courts to employ in formulating a body of common law. Burdening the estate of a deceased plan participant with a hospital bill in excess of $350,000.00, because the deceased beneficiary was unable to communicate information to the hospital as to his coverage prior to his benefit plan's time period for filing a claim elapsed clearly contravenes ERISA's recognized remedial purposes.

The petitioner Baptist Memorial Hospital respectfully submits that the Court should issue a writ of certiorari to the Court of Appeals for the Sixth Circuit.

Respectfully submitted,

/s/_____
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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

NOT RECOMMENDED FOR FULL-TEXT PUBLICATION

[Filed February 16, 2000]

No. 98-6288

BAPTIST MEMORIAL HOSPITAL
Plaintiff-Appellant,

v.

EMMA MARSAW, Individually and as the Personal Representative of the Estate of David Marsaw, Deceased; DONNA SHALALA, Secretary of Health and Human Services; FORD UAW RETIREE PROGRAM;
Defendants,

BAKERY & CONFECTIONARY UNION &INDUSTRY INTERNATIONAL HEALTH BENEFITS FUND,
Defendant-Appellee.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF TENNESSEE

OPINION

Before: COLE and GILMAN, Circuit Judges; and CARR,* District Judge.

PER CURIAM. Plaintiff-Appellant Baptist Memorial Hospital ("BMH") appeals the order of the district court granting Defendant-Appellee Bakery & Confectionary Union & Industry International Health Benefits Fund's ("the Fund") motion for summary judgment and denying BMH's motion for summary judgment.

I.

BMH filed a "Complaint for Declaratory Judgment and Damages" under 28 U.S.C. § 2201. 42 U.S.C. §§ 1395 and 1395y(b), and 29 U.S.C. §§ 1101, *et seq.*, the Employee Retirement Income Security Act of 1974 (ERISA). BMH claimed that the Fund owed it $355,216.33[1] for hospital services provided to David Marsaw, the dependent of a Fund beneficiary. The Fund denied payment of BMH's claim on the basis that the claim was submitted to the Fund long after

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* The Honorable James G. Carr, United States District Judge for the Northern District of Ohio, sitting by designation.

[1] The district court refers to a slightly different figure -- $356,984.57 -- as the amount of hospital charges incurred by Marsaw. We refer to the figure found in BMH's complaint. *See* J.A. at 23.

the Fund's limitation period for showing proof of loss had run and because Marsaw was admitted to BMH without obtaining certification as required under the Fund's plan.

II.

On appeal, BMH argues that the district court erred by failing to apply federal common law to equitably toll the limitation period for submitting a claim to the Fund. BMH also argues that the district court erred by failing to apply the role of *contra proferentem* to language in the Fund's summary plan description ("SPD"). Finally, BMH argues that the court erred by failing to find that the Fund's denial of BMH's claim was arbitrary in light of the Fund's practice of paying de minimis claims submitted after the limitations period.

In its published decision, the district court detailed the factual and procedural background of this case and articulated sound reasoning supporting its grant of summary judgment to the Fund and its denial of summary judgment to BMH. *See Baptist Mem'l Hosp. v. Marsaw,* 13 F. Supp. 2d 696 (W.D. Tenn. 1998). After hearing oral argument and carefully considering the record, the briefs of the parties, and the applicable law, we are convinced that there are no issues of material fact in this case and that the Fund is entitled to summary judgment as a matter of law. *See* Fed. R. Civ. P. 56(c). As issuance of a detailed written opinion by this court would be duplicative and would serve no useful purpose, we AFFIRM the judgment of the district court based upon the reasoning of its July 9, 1998 decision.

In affirming the district court's decision, we note that the decision does not address *Branch v. G. Bernd Co.*, 955

F.2d 1574 (11th Cir. 1992), a case on which BMH relied substantially in its appeal to this court. In *Branch,* the Eleventh Circuit applied equitable tolling principles to the election period of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), 29 U.S.C. § 1161 *et seq.* *Branch*, 955 F.2d at 1580-82. We find *Branch* inapposite to the instant case. The *Branch* court applied equitable tolling principles based upon Congress's purpose in enacting COBRA, which the court found to be "to 'provide continued access to affordable private health insurance.'" *Id.* at 1580 (quoting H.R. Rep. No. 241, Part 1, 99th Cong., 2d Sess. 44, *reprinted in* 1986 U.S.C.C.A.N. 579, 622). This purpose was manifested in a statutorily required minimum election period. *Id* at 1580-81 (citing 29 U.S.C. § 1161). BMH's claim, of course, does not arise under COBRA, and the limitations period BMH seeks to toll was provided by the Fund's plan rather than mandated by statute. *See* 29 U.S.C. §§ 1102; 1022. This court has noted that "[a] primary purpose of ERISA is to ensure the integrity and primacy of . . . written plans." *Health Cost Controls v. Isbell,* 139 F.3d 1070, 1072 (6th Cir. 1997). Further, "the plain language of an ERISA plan should be given its literal and natural meaning," and "federal courts may not apply common law theories to alter the express terms of written benefit plans." *Id.* Because the Fund's SPD expressly states the limitations period for benefits claims, *see Baptist,* 13 F. Supp. 2d at 701, any application of federal common law tolling principles such as those applied by the *Branch* court would vitiate the primacy and integrity of the Fund's written plan.

III.

For the reasons expressed in the district court's July 9, 1998 opinion and those discussed herein, we AFFIRM the opinion of the district court.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

[Filed July 9, 1998]

No. 95-2241-TUV

BAPTIST MEMORIAL HOSPITAL, *Plaintiff*,	)
v.	)
EMMA MARSAW, individually and as the personal representative of the Estate of David Marsaw, deceased, BAKERY & CONFECTIONERY UNION & INDUSTRY INTERNATIONAL HEALTH BENEFITS FUND, DONNA SHALALA, Secretary of Health and Human Services, and FORD UAW RETIREE PROGRAM, *Defendants*.	)

ORDER ON CROSS-MOTIONS FOR SUMMARY JUDGMENT

Pursuant to the federal Declaratory Judgment Act, 28 U.S.C. § 2201, and the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1101, et seq., Baptist Memorial Hospital ("BMH") requests that this court declare the rights and obligations of BHM and the Bakery and Confectionery Union and Industry International Health Benefits Fund[1] (the "Fund") with respect to $356,984.57 in hospital charges incurred by David Marsaw, deceased, during a lengthy inpatient admission. Before the court are BMH's and the Fund's cross-motions for summary judgment.

I. Summary Judgment Standard

The moving party is entitled to summary judgment where, there is no genuine issue of material fact and the party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c). When considering a motion for summary judgment, the court's function is not to weigh the evidence or judge its truth; rather, the court must determine whether there is a genuine issue for trial. Anderson v. Liberty Lobby, Inc., 477

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[1] Pursuant to this court's prior orders of dismissal from this lawsuit of Donna Shalala, the Ford UAW Retiree Program, and Emma Marsaw in her individual capacity, only BMH's claims against the Fund and Emma Marsaw in her capacity as the personal representative of the Estate of David Marsaw remain. Because BMH agreed to stay its claim against Emma Marsaw in her capacity as the personal representative of the Estate of David Marsaw, the court's order addresses only BMH's claim against the Fund.

U.S. 242, 254 (1986). The substantive law governing the case will determine what issues of fact are material. Street v. J.C. Bradford & Co. 886 F.2d 1472, 1479 (6th Cir. 1989).

A summary judgment movant "bears the burden of clearly and convincingly establishing the nonexistence of any genuine issue of material fact and the evidence as well as all inferences drawn therefrom must be read in a light most favorable to the party opposing the motion." Kochins v. Linden-Alimak, Inc., 799 F.2d 1128, 1133 (6th Cir. 1986). Once met, the burden shifts to the non-moving party to set forth specific facts showing a genuine issue of triable fact. Fed. R. Civ. P. 56(e). To meet this burden, the non-movant must present sufficient countervailing evidence such that a jury could return a verdict favorable to the non-moving party. Anderson, 477 U.S. at 249-50.

Where the parties have submitted cross-motions for summary judgment, the court addresses "each party's motion on its own merits, taking care in each instance to draw all reasonable inferences against the party whose motion is under consideration." Taft Broadcasting Co. v. United States, 929 F.2d 240, 248 (6th Cir. 1991) (quoting Mingus Constructors, Inc. v. United States, 812 F.2d 1387, 1391 (Fed. Cir. 1987)). Moreover, the fact that both parties have submitted motions for summary judgment does not require the court to find that no issue of material fact exists. Id. (citing Begnaud v. White, 170 F.2d 323, 327 (6th Cir. 1948)). In short, "summary judgment in favor of either party is not proper if disputes remain as to material facts." Id. (citing Mingus 812 F.2d at 1391).

II. Background

The parties do not dispute the following facts. While visiting his sister in Memphis, Tennessee, Mr. Marsaw, a resident of Chicago, Illinois, began experiencing physical difficulties that compelled him to seek medical assistance. On September 12, 1991, Dr. Thomas West admitted David Marsaw to BMH through the emergency department with the principal diagnoses of (1) Parkinson's disease and (2) urinary bladder neck contracture with bladder outlet obstruction, and with the secondary diagnoses of (1) Parkinson's dementia complex; (2) cor pulmonale; (3) subendocardial myocardial injury; (4) respiratory failure; and (5) hyporegenerative anemia. Mr. Marsaw remained hospitalized at BMH until March 4, 1992.

Following three operative procedures, Mr. Marsaw experienced excellent relief from the bladder obstruction and resulting fluid retention. However, over the next several months, Mr. Marsaw endured multiple episodes of respiratory failure that required him to spend much of his lengthy hospitalization in the intensive care unit on a respirator. Additionally, Mr. Marsaw's mild confusion, evident at admission, worsened until he became, as his doctor described, "frankly demented."

At the time of his 1991 admission to BMH, Mr. Marsaw possessed three potential sources for health insurance coverage: (1) Medicare, as an individual over age 65; (2) the Ford UAW Retiree Program ("Ford Program"), as a retired employee of the Ford Motor Company; and (3) the Baker and Confectionery Union and Industry International Health Benefits Fund, as the retired husband of Emma Marsaw, an

actively employed Nabisco Brands, Inc. employee. During his emergency admission, with his wife at home in Chicago, Mr. Marsaw, whose dementia limited his ability to convey information, was accompanied only by his sister. They offered medical cards that demonstrated Mr. Marsaw's Medicare and Ford Program coverage, but made no reference to coverage under the defendant Fund. The limited information received by BMH did not even reveal Mr. Marsaw's marriage to Emma Marsaw. During his admission to the hospital, Mr. Marsaw assigned to BMH all of his rights to receive health benefits.

BMH discovered that the Ford Program provided Mr. Marsaw with coverage under a Blue Cross/Blue Shield of Michigan Plan and a Humana Health Maintenance Organization. These benefits, however, would not cover Mr. Marsaw's BMH expenses because the Blue Cross/Blue Shield plan included only vision and dental expenses and BMH was not a participating provider in the Humana HMO. As a result, BMH listed Medicare as Mr. Marsaw's primary payer and submitted claims to the Medicare intermediary, Blue Cross/Blue Shield of Tennessee ("Medicare intermediary"), for reimbursement.

After discovering in November of 1993 that another payer had paid primary health benefits on behalf of Mr. Marsaw to other health care providers, pursuant to federal

law[2] the Medicare intermediary denied BMH's claims for reimbursement from Medicare as the primary payer, but did not tell the hospital of the identity of the primary payer at that time. On February 21, 1994, almost two years following the date of Mr. Marsaw's discharge, the Medicare intermediary advised BMH that the Bakery and Confectionery Union and Industry International Health Benefits Fund was the entity that had paid primary benefits on behalf of David Marsaw to other health care providers. BMH immediately contacted the Fund and submitted a claim for Mr. Marsaw's hospital charges. The Fund denied BMH's claim on the grounds that Mr. Marsaw's emergency admission was not certified within 48 hours of admission and because the claim for benefits was made beyond the one-year limitations period set out in the Fund's Summary Plan Description ("SPD").[3] Following BMH's submission of evidence regarding Mr. Marsaw's incapacity during his hospitalization and the resulting inability of BMH to discover the Fund's existence, the Fund's Appeals

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[2] Under the "Medicare as secondary payer" provisions of the Medicare program, employee group health plans are generally the primary payers of medical expenses and Medicare is the secondary payer. 42 U.S.C. § 1395y(b).

[3] At the time of Mr. Marsaw's hospitalization, the SPD expressly required beneficiaries to offer proof of loss within 90 days of the loss. However, following a consistent practice of requiring proof of loss to be submitted within one year of the loss, the Fund formally amended the SPD to require submission of proof of loss within one year of a loss. The parties do not dispute that the Fund used the one-year rule for evaluating BMH's claim on appeal.

Committee[4] denied BMH's internal appeal for the reasons originally given. The Fund does not dispute that it would be responsible as a primary payer for Mr. Marsaw's expenses but for the failure to obtain certification following Mr. Marsaw's emergency admission and the failure of BMH to submit proof of loss within the Fund's limitation period.

In this appeal of the Fund's denial of benefits, BMH argues that it should be granted equitable relief from the trustees' decision, because the hospital's lack of knowledge of the Fund's existence and Mr. Marsaw's incompetency during the relevant time period excused the hospital's delay from filing proof of loss within the Fund's limitation period. In support of its position, BMH argues that federal courts are authorized to develop a uniform federal common law to supplement the explicit provisions and general policies set out in ERISA. Based on this premise, BMH encourages the court to follow three Tennessee common law principles from the field of insurance law in the instant case: (1) ignorance of the existence of a policy of insurance will excuse delay in giving notice and furnishing proofs of loss; (2) provisions requiring

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[4] The Fund is administered by a Board of Trustees, half of whom are selected from among the employers participating in the Fund and half of whom are selected from among the unions participating in the Fund. The Fund's administrative office staff, which consists of approximately 62 employees, initially reviews benefits claims in light of the Fund's written documents governing the payment of benefits. Following this decision, beneficiaries may appeal denials to the Appeals Committee of the Board of Trustees, consisting of the Fund's Chairman and Secretary. If proper, the Appeals Committee's decisions are then ratified by the full Board of Trustees.

a timely filing of a proof of loss are liberally construed in favor of the insured; and (3) unless an insurance policy contains an express forfeiture clause for the failure to file proof of loss within a specified time, delay will not result in a loss of benefits, provided the claimant's delay was not the result of his own negligence.

Additionally, BMH seeks to import the common law doctrine of contra proferentum, which compels a court to construe ambiguous terms of a written document against the party who selected them. In applying the rule of contra proferentum to the instant matter, BMH attempts to demonstrate two ambiguities in the Fund's SPD. BMH first argues that the meaning of the term "loss" in the Fund's SPD is ambiguous, and, therefore, the triggering event for the specified time in which to file a claim, which is the occurrence of "loss," is also ambiguous. Second, BMH contends that the Fund's failure to specify the consequences of failing to submit proof of loss within the SPD's limitation period aiso creates ambiguity. Thus, according to BMH, the Fund's trustees abused their discretion by basing their decision to deny BMH's claim on these allegedly ambiguous terms.

BMH further argues that the Fund's policy to pay claims submitted beyond the SPD's limitation period "where the amount in issue is so de minimis that the costs of considering an appeal would be greater than the costs of paying the claim" renders its present decision to deny BMH's claim arbitrary.

In response to BMH's contentions, the Fund argues that the trustees' denial of benefits should be reviewed under

the arbitrary and capricious standard. The Fund therefore argues that because the Fund trustees, at a minimum, rationally interpreted the SPD's post-emergency admission certification requirement and time limitation for filing claims in denying BMH's claim, the reasons for BMH's delay are irrelevant, in that the court must defer to the trustees' rational interpretations under the arbitrary capricious standard of review.

III. Standard of Review for the Trustees's Denial of Benefits

The parties do not dispute that the Fund is a multiemployer welfare plan subject to the provisions of ERISA. See 29 U.S.C. 1002(1), 1002(37)(A), 1003(a). Denials of benefits by ERISA employee benefit plan administrators or fiduciaries are to be reviewed under an arbitrary and capricious standard if the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan. Perry v. United Food & Commercial Workers Dist. Unions, 64 F.3d 238, 242 (6th Cir. 1995) (quoting Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989)). According to the Fund's Trust Agreement, its trustees have: (1) "full authority to determine all questions of nature, amount and duration of benefits to be provided"; (2) "full authority to determine eligibility requirements for benefits and to adopt rules and regulations setting forth same"; and (3) "full authority to determine all claims for benefits." (Bergin Decl. ¶ 2, Ex. 1, at 5-6 (Art. VI)). Although no court within the Sixth Circuit has considered whether the Fund's trustees exercise sufficient discretion to warrant deferential review, in an unpublished decision the United States District Court for

the Southern District of Illinois concluded that the Fund's trustees exercised sufficient discretion to justify invocation of the arbitrary and capricious standard. See Renfro v. Bakery & Confectionery Union & Indus. Int'l Health Benefits & Pension Fund, Civ. No. 94-210 (S.D. Ill. Nov. 10, 1994). Moreover, the Sixth Circuit has consistently held that plans with substantially similar discretionary language warrant deferential review. See, e.g., Johnson v. Eaton Corp., 970 F.2d 1569, 1571 (6th Cir. 1992) (finding that arbitrary and capricious standard applies where the plan provides that the pension committee "'shall have all such powers and authority as may be necessary to carry out the provisions of this plan'") (quoting plan); Baker v. UMWA Health & Retirement Funds, 929 F.2d 1140, 1144 (6th Cir. 1991) (concluding that abuse of discretion standard applies where plan provides that the trustees "'shall have full and final determination as to all issues concerning eligibility for benefits'") (quoting plan); Davis v. Kentucky Fin. Cos. Retirement Plan, 887 F.2d 689, 694 (6th Cir. 1989) (finding that arbitrary and capricious standard applies where plan provided that the administrator "'shall interpret the Plan and shall determine all questions arising in the administration, interpretation, and application of the Plan'") (quoting plan). Accordingly, the court will apply an arbitrary and capricious standard of review in the instant case.

The Sixth Circuit has further explained that the arbitrary and capricious standard "is the least demanding form of judicial review of administrative action. . . . When it is possible to offer a reasoned explanation, based on the evidence, for a particular outcome, that outcome is not arbitrary and capricious." Perry, 64 F.3d at 242. Under this deferential standard, when the parties offer rational but

conflicting interpretations of an ambiguous ERISA plan term, the court should defer to the plan administrator's rational interpretation. See Johnson v. Eaton Corp., 970 F.2d 1569, 1572 (6th Cir. 1992) (deferring to ERISA plan administrator's reasonable interpretation of ambiguous plan term despite beneficiary's offer of conflicting reasonable interpretation of same term). Accordingly, to the extent that BMH can show that Fund trustees relied upon ambiguous plan terms in denying BMH's claim, the court will nonetheless defer to the Fund trustees' interpretation if it is reasonable.

IV. BMH's Alleged Ambiguities in the Fund's Summary Plan Description

A. The Fund's Limitation Period for Submission of Proof of Loss

According to the Fund's SPD, as a condition for the receipt of benefits, proof of loss on which a claim is based must be furnished to the Fund Office within one year of the date of such loss. It is therefore the occurrence of "loss" that triggers the plan's one-year limitation period. BMH argues that the SPD fails to specify when loss occurs for purposes of triggering the limitation period, and, therefore, the trustees' interpretation of loss to mean the date on which service is rendered is an arbitrary interpretation of an ambiguous term. An examination of the terms of the SPD reveals that BHM's argument lacks merit. Under the SPD, hospital expenses are paid only if they are "covered expenses." (Bergin Decl. ¶ 8, Ex. 2, at 25, 37). Thus, a "loss on which a claim may be based" can refer only to a "covered expense." The SPD further provides that a "covered expense is incurred as of: a) in the case of a service, the date the service is rendered, or b)

in the case of a supply, the date the supply is purchased." (Id. at ¶ 9, Ex.2, at 25). The terms of the SPD therefore not only demonstrate the lack of ambiguity concerning the date on which a beneficiary incurs loss, but, at a minimum, also show the rationality of the Fund trustees' interpretation of the date on which loss is incurred.

B. Forfeiture of Benefits Due to Failure to Comply with Fund's Limitation Period

BMH argues that the SPD fails to specify that noncompliance with the claim limitation period forfeits all benefits for the untimely claim, and, therefore, the trustees' imposition of a complete forfeiture of benefits in the event of an untimely claim is an arbitrary interpretation of the SPD. Again, examination of the SPD disposes of BMH's argument. The SPD defines the conditions precedent for the receipt of Fund benefits, and the requirement that proof of loss "must be furnished to the Fund Office" within one year of the loss "logically and unambiguously establish[es] that, under the [SPD], timely submission of proof is a condition precedent to the payment of benefits." See Cisneros v. UNUM Life Ins. Co. of Am., 134 F.3d 939, 943 (9th Cir. 1998) ("We also reject [plaintiff's] contention that the [ERISA] Policy failed to provide expressly for forfeiture of benefits in the event of untimely submission of proof. [The Policy] provides that proof 'may not be given' after one year and 180 days . . . [and further provides] that benefits will be paid '[w]hen the company receives proof.' Read together, these provisions logically and unambiguously establish that, under the Policy, timely submission of proof is a condition precedent to the payment of benefits."); Moon v. White, 909 F. Supp. 1047, 1054 (E.D. Tenn. 1993) (finding that even though ERISA

policy failed to specify the consequence of noncompliance with limitation period, "a reasonable person in [plaintiff's] position would understand the proof-of-loss provisions in the two policies in issue to state outside time limits for submitting proofs of loss, and would understand these time limits, like statutes of limitations, to bar claims submitted too late"). At the very least, the trustees rationally interpreted the SPD to require forfeiture of benefits for untimely claims.

V. The Applicability of Contra Proferentum

The lack of ambiguity in the challenged SPD provisions forecloses BMH's request that the court import the doctrine of contra proferentum into ERISA case law. See Moon, 909 F. Supp. at 1054 (deciding not to invoke rule of contra proferentum because "the rule is invoked only upon a finding of an ambiguity in the plan being construed") (citing Phillips v. Lincoln Nat'l Life Ins. Co., 978 F.2d 302 (7th Cir. 1992)). However, assuming that BMH could show ambiguity in the SPD provisions it challenges, Sixth Circuit precedent establishes that courts, when applying the arbitrary and capricious standard of review, should defer to an ERISA plan fiduciary's rational interpretation of an ambiguous term. See Eaton, 970 F.2d at 1572 (deferring to ERISA plan administrator's reasonable interpretation of ambiguous plan term despite beneficiary's offer of conflicting reasonable interpretation of same term).

Moreover, the courts of appeals cases relied upon by BMH for the proposition that federal appellate courts have been invoking contra proferentum in ERISA cases are specific to scenarios in which the plan documents were drafted by the insurance company that was administering the plan on behalf

of the employer. See Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534, 539-40 (9th Cir. 1990) (applying contra proferentum to an insurance company-drafted ERISA policy because "an insurer's practice of forcing the insured to guess and hope regarding the scope of coverage requires that any doubts be resolved in favor of the party who has been placed in such a predicament"); Phillips, 978 F.2d at 312-13 (relying on Kunin and reaching same conclusion). In circumstances in which the ERISA plan is self-funded and plan documents are the product of collective bargaining, the same federal appellate courts have held that contra proferentum does not apply, because concerns about unequal bargaining power are eliminated. See Eley v. Boeing Co., 945 F.2d 276, 279-80 (9th Cir. 1991) (declining to apply contra proferentum when reviewing an ambiguous provision of a self-funded plan resulting from a collective bargaining agreement, and distinguishing Kunin as not applying to plans that result from collective bargaining); see also Phillips, 978 F.2d at 314 (explaining that contra proferentum is inapplicable where the insured is a co-drafter of the policy) (citing Northbrook Excess & Surplus Ins. Co. v. Proctor & Gamble Co., 924 F.2d 633, 639 (7th Cir. 1991)); Taylor v. Continental Group Change in Control Severance Pay Plan, 933 F.2d 1227, 1233-34 (3d Cir. 1991) (declining to use contra proferentum to review the terms of a self-funded ERISA plan and distinguishing Kunin as applying to insurance contracts). Accordingly, to the extent that there is ambiguity in the SPD terms challenged by BMH, the court should not invoke the rule of contra proferentum, but should defer to the Fund trustees' rational interpretation, because the Fund, a self-insured ERISA plan, is the product of collective bargaining. As a result, the court finds that BMH's argument for the

application of contra proferentum in the instant case lacks merit.

VI. The Fund's Payment of Untimely Claims Where the Costs of Considering Appeal Are Greater than Payment of the Claim

The Fund admits that it routinely pays untimely claims where the claim is so de minimis that it would be more costly to consider an appeal of the denied claim than to pay the claim. BMH argues that distinguishing between claims on this basis is arbitrary and capricious. The Fund persuasively responds that the interest of preserving Fund assets makes it reasonable to pay untimely de minimis claims rather than incur the greater cost of the appeal process. Although the consistent application of plan terms is a legitimate factor when reviewing fiduciary action under the arbitrary and capricious standard, there is no evidence in the record that the Fund has ever paid an untimely claim that exceeded the costs of appeal. See Cash v. Wal-Mart Group Health Plan, 107 F.3d 637, 641 (8th Cir. 1997) (explaining that consistent interpretation of relevant plan terms is relevant to whether ERISA plan fiduciaries' challenged interpretation is reasonable). Accordingly, the court concludes that the Fund's application of its de minimis rule in the instant matter is not arbitrary and capricious.

VII. The Propriety of Supplanting an Administrator's Rational Interpretation of an ERISA Plan Term Through the Creation of Federal Common Law

The preceding analysis demonstrates that the Fund's denial of BMH's claim arises from rational interpretations of the terms of the SPD. Considering the degree of discretion ceded to the Fund's trustees, Firestone, supra, strictly applied, compels the court to defer to the trustees' decision. BMH, however, argues that the court should nonetheless grant it equitable relief from the Fund's denial of benefits considering BMH's complete inability to discover the existence of the plan before the expiration of the SPD's limitation period. Thus, the court reaches the controlling issue in this case: When applying the arbitrary and capricious standard of review, may the court supplant an ERISA plan administrator's rational interpretation of an ERISA plan term through the creation and implementation of an equitable remedy under the auspices of federal common law?

Considering the deference owed to the trustees' decision and the general rule that a federal court may not alter the substantive terms of an ERISA benefits plan unless the challenged, term contravenes an ERISA policy, the court must answer this question in the negative. See Moore v. Reynolds Metals Co. Retirement Program for Salaried Employees, 740 F.2d 454, 457 (6th Cir. 1984) (holding that (1) an employer is free to choose what benefits and terms to include in the plan as long as ERISA law and policy are not violated, and (2) judicial review of denial of benefits is limited "to a determination of whether the trustees' actions in administering or interpreting a plan's provisions are arbitrary and

capricious"); Nazay v. Miller, 949 F.2d 1323, 1337 (3d Cir. 1991) (finding that "the only substantive review a court may make is to ensure that the plan does not violate ERISA's purpose" and reversing the district court's decision to "transplant" into the ERISA setting a common law "notice/prejudice" rule because the ERISA plan's precertification requirement did not violate any "fundamental ERISA-based policy"). While rigid application of the Fund's limitation period may produce a harsh result in this case, by protecting the fiscal stability of the Fund, the Fund's one-year rule nonetheless furthers the fundamental ERISA policy of "enhanced protection" of employee benefits. Varity Corp. v. Howe, 516 U.S. 489, 497 (1996). As Robert Bergin, the Fund's Executive Director, explained in his declaration:

> The one-year rule aids in long-term planning by enabling the Fund to learn relatively quickly whether it has large liabilities that may warrant the establishment of reserves. It also minimizes the extent to which the Fund must pay bad claims due to the inability to properly evaluate their validity because it enables the Fund to make inquiries, relatively contemporaneously with the services provided, into such matters as the consistency of the service provided with the diagnosis and the appropriateness of the particular service.

(Bergin Decl. at ¶ 12). Because the SPD's post-emergency admission certification requirement and time limitation for filing claims do not violate any fundamental ERISA policy, the court will not import BMH's requested equitable remedy to effectively rewrite these legitimate plan provisions. See St. Joseph Hosp. v. Kansas Bldg. Trades Open End Health &

Welfare Trust Fund, 1988 U.S. Dist. Lexis 17853 at *8-9 (W.D. Mo. Sept. 13, 1988) (upholding trustees' denial of medical benefits due to failure to file within the plan's specified time limit, because "[t]his court 'will not disturb the decisions of administrators of an employee welfare benefit plan such as this unless those decisions were arbitrary and capricious'") (quoting Agee v. Armour Foods Co., 672 F. Supp. 1210, 1217 (W.D. Mo. 1986), aff'd, 834 F.2d 144 (8th Cir. 1987)); Scheirer v. NMU Pension & Welfare Plan, 585 F. Supp. 76, 79 (S.D.N.Y. 1984) (upholding trustees' denial of benefits under a welfare fund where the claim was not filed by the filing deadline set forth in the plan).

To support the propriety of fashioning an equitable remedy in this case, BMH directs the court to the Seventh Circuit's decision in Doe v. Blue Cross & Blue Shield United of Wisconsin, 112 F.3d 869 (1997). In Doe, the Seventh Circuit applied the doctrine of equitable estoppel to preclude an ERISA governed benefits plan from invoking its limitation period to bar the plaintiff's claim for benefits. Id. at 876-77. BMH's reliance on Doe is misplaced. Recognizing that "the applicability of estoppel principles in ERISA cases is controversial because ERISA forbids the conferral of benefits other than in accordance with the written ERISA plan," id. at 875, the Seventh Circuit explained that the correspondence that served as the foundation for plaintiff's estoppel argument amounted to a written modification of the underlying contract for benefits and, therefore, eliminated the need to look beyond the terms of the plan in granting plaintiff's relief. Writing for the panel, Judge Posner explained:

> We are not even sure that it is necessary to get into considerations of what is equitable. In

> effect, the defendants offered the plaintiff a tolling agreement of indefinite duration but expiring when settlement negotiations finally broke down, and the plaintiff accepted, thereby binding the defendants. It was a contract embedded within the larger contract constituted by the benefits plan. In such a case the application of the doctrine of equitable estoppel is nothing exotic; it amounts to nothing more than the application of basic contract principles.

Id. at 877. As no evidence in the record suggests that the Fund represented to BMH that it would modify its limitation period, the court concludes that the Seventh Circuit's analysis in Doe does not affect the court's decision in this case.

VII. Conclusion

For the foregoing reasons, the court finds that there are no genuine issues of material fact regarding the rationality of the Fund's decision to deny BMH's claim for benefits. The court grants the Fund's motion for summary judgment and denies BMH's motion for summary judgment. Accordingly, the court holds that the Fund is not liable under its plan to BMH for the losses incurred by David Marsaw.

IT IS SO ORDERED this 9th day of July, 1998.

/s/_____
JEROME TURNER
UNITED STATES DISTRICT JUDGE

APPENDIX C

29 U.S.C. § 1132

Section 502(a) of ERISA provides, in pertinent part, as follows:

> (a) Persons empowered to bring a civil action
>
> A civil action may be brought --
>
> (1) by a participant or beneficiary --
>
> * * *
>
> (B) to recover benefits due him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;
>
> * * *
>
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the

> plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;
>
> * * *

29 U.S.C. §1133.

Section 503 of ERISA provides in its entirety as follows:

> In accordance with regulations of the Secretary [of Health and Human Services], every employee benefit plan shall --
>
> > (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
> >
> > (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate

named beneficiary of the decision denying the claim.

29 U.S.C. §1144.

Section 514 of ERISA provides, in pertinent part, as follows:

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

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